

Provocative Idea:

Art Portraying Medicine

Kaisu Koski

Faculty of Art and Design, University of Lapland

PO Box 122, FI-96101 Rovaniemi, FINLAND

livingorganism@gmail.com

Abstract

A number of art projects are currently tackling the medical domain. This activity stems from a perceived need to increase the transparency and democracy of the medical domain, and it often questions the power relations and the one-dimensionality in current medical practices. This article sheds light on how artists process medical themes, elaborates on research elements embedded in art making processes, and considers the relevance of artists' projects for researchers from other disciplines. It deliberates on the author's media and performance art practice in exploring the doctor-patient relationship and discusses the artistic methods and techniques employed. The article promotes the personal, imaginative, and figurative characteristics in the discussion and signification of the body in medicine.

Keywords: doctor-patient relationship; performance; video art; binary oppositions

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1. Introduction

As a practicing media and performance artist my work has revolved around medical themes, such as placebo effect, medical visualization technologies, medicine commercials, and doctor-patient relationship. Accordingly, the case study artworks discussed in this article explore the discourse in portraying the human body as a patient and a doctor. This discourse is manifested in the physical performance of modern medicine as the result of a certain body conception. In fact, at the core of modern medicine lies the Cartesian revelation of seeing a living body similar to a machine (Leder, 1992, p. 23). In my practice, however, the patients' and doctors' bodies are considered as constructed mixtures of discourse and matter that are both bound up with an experienced world and a biological reality (see Lupton, 1994, p. 22). Furthermore, I wish to problematize the conventional view of patients as objects of a doctor's manipulation by seeing that doctors' bodies are also mere instruments and restricted in many ways (see Hirschauer, 1991). The particular case study artworks discussed in this article focus on the hierarchy embedded in the doctor-patient relationship, as it manifests in gazes and choreographies in the consultation room environment.

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Even though artists often engage with some kind of research in their work processes, these activities are distinct from (most) academic research conceptions (see Frayling, 1993). While the emerging field of artistic research aims to develop methodological-philosophical ground for art practice as a form and/or part of academic research, the case study artworks discussed in this article are not produced within such framework. The artworks discussed here are thus not promoted as research, since they draw from the existing knowledge base instead of aiming to produce new knowledge (Scrivener, 2009, p. 70). Rather, they pour inspiration and concepts from (research in) medicine, philosophy, and anthropology, and translate these in artistic account on medicine, thus portraying medicine with artistic means.

2. Medicine and Artists: Host and Strangers

From a historical perspective artists are not strangers to the medical domain. Before the development of medical imaging technologies, for instance, artists used to create the majority of the medical visualizations. Furthermore, art and medicine were not strictly separated disciplines: some artists even possessed medical skills, as the production of medical images was based on dissecting bodies (see Wildevuur, 2009, p. 12). Even though the artists' role as medical visualization specialists has decreased, their expertise is increasingly employed in medical education in training perceptual and performance skills of the medical students (e.g., the Performing Medicine initiative by the UK-based theatre group, Clod Ensemble), supporting the students' creative explorations (e.g., the Medical Humanities course at the University of Southampton), and in several artsmedicine research programs in medical faculties (e.g., Stanford University, University of Alberta, Dalhousie University).

Artists thus enter the medial domain with various agendas. This article introduces art projects, in which I employ imagery from real medical environments. In such cases there are several considerations before actually beginning the production. Collaboration with the medical domain introduces, in fact, a set of ethical questions: hospitals are concerned with their reputation and do not wish to be linked to anything provocative, or even themes such as death. As an artist I need to search for a balance between remaining autonomous and being allowed to position myself within the medical domain. However, the dilemma remains complex: even if I gain permission to use a doctor's or patient's images, there might be a different understanding of the context in which these images are placed within an artwork. In fact, working with professional performers or, as often in my work, using my own images are the only ways to ensure that nobody is unwillingly exposed.

In my aim to explore a culture beyond my “native” field, and to communicate my findings through visual reflections, my activity has similarities with that of an (visual) anthropologist. More specifically, as my projects stage the medical objects in the context of art, involving my personal viewpoint, they have similarities with methods such as *performance ethnography* and *autoethnography*. Like many artists, the adapter in performance ethnography prepares and stages a script employing texts collected from the field, and the characters of such compositions provide the analytical points and the commentary (McCall, 2003, pp. 122-123). Autoethnography, in turn, inserts the researcher's personal experiences in the project (Denzin, 2003, p. 33), a feature that most artistic projects share. Even though my personal experience is not the object of portrayal as such, an autoethnographic approach resembles my practice as it attempts to disrupt the binary of science and art, and it recognizes the influence of a personal experience on the research process (see Ellis, Adams, & Bochner, 2011). As I visit a “medical tribe” and study their environment, I simultaneously try to hear my own voice with respect to my findings. That is, being embedded, doing interviews and role-plays, enables me to select or develop techniques and methods with which to visualize the (potential) landscape of this tribe. The artistic practices thus celebrate the imaginative potential of the mind, while employing training in perceptual and composition skills and techniques to use instruments

such as a camera and the body. MacDougall (2006, p. 213) notes, in fact, that even though anthropology has an interest in the visual, the problem has always been what to do with the visual dimension. In this regard I consider artists to have a significantly different relationship with, and knowledge of, visual media than researchers within medicine and social studies.

Even though I wish to avoid a one-dimensional judgment on the medical domain, I take a critical standpoint towards current medical practices. The artworks thus have, intentionally or unintentionally, a moral dimension within. Carroll (1998, pp. 141-142), in fact, suggests that art can function as an exercise of moral and emotional knowledge that one already possesses. This exercise can be realized not only by viewing art in a gallery context: art, especially films and literature, are widely used in medical education as a source of discussion on particular moral questions (see, e.g., Silenzio, Irvine, Sember, & Bregman, 2005). From this viewpoint the artists' task is not to offer solutions to biomedical dilemmas, nor to seek a therapeutic health benefit. Instead, as Broderick (2011, p. 3) notes, arts practices can open a discursive space that can comment and critique the relationship between medicine and society. Accordingly, Düwell (1999, p. 167) suggests that an aesthetic experience affords one a reflexive distance, which opens up new possibilities for action, introduces new ways of looking at the world and makes one more sensitive to human needs. The relevance of narrative dimension is currently recognized in clinical practice as well: Charon (2001) introduces a practice of narrative medicine, in which the clinician is competent to recognize, interpret, and move to action by the dilemmas of others.

3. Artists' Methods

The particular qualities of my art projects manifest themselves as a personal fascination with and experiences in the medical domain, which, in fact, motivate the whole activity. In the process of an artwork I inevitably take position(s) in relation to the medical field, thus the universal, and ask continuously, where I am within it. Artistic methods do not aim to camouflage the presence of the artist, or to be objective or disinterested, but they render the artist's presence visible as a key characteristic of them. The composition constructed evolves by "processing" the universal through the personal. By opening up and staging the personal dimension in the project an artist opens up a channel to more holistic communication: she speaks not only from a critical and analytical viewpoint but recognizes and translates her emotional-corporeal experience. During the process the artist functions constantly as a resonating membrane, which, in turn, transforms the dialogue, resulting from the dialogue between the medical practice and the personal, into material. As a media and performance artist I approach medical bodies with a language similar to what they employ: in my work the performing body unravels the performativity of the bodies within the medical domain. As the objects of portrayal are processes, my methods are also time-based interventions, relying essentially on production of new video imageries. Two significant instruments in this are a camera and the body.

In order to address the chosen medical situations, I employ several performative and qualitative techniques and concepts. As a starting point I distinguish a binary opposition of doctor/patient, which I deconstruct through performance and visual imageries. While Jacques Derrida (1976) introduces binary oppositions as a deconstructionist concept, the opposition pairs have been employed already in structuralism and the Surrealist movement. According to Derrida (1981, p. 39), within any particular culture, one of the opposition terms is always privileged and dominating the other. Furthermore, he continues, in order to deconstruct an opposition, one needs to not only provoke the overturn of the hierarchy, but also to disorganize the entire inherited order. I employ the concept's central features in my audiovisual compositions as a point of departure in exploring the hierarchy of the doctor-patient binary pair. In this process I address a doctor and a patient as a culturally constructed opposition pair, which archetypically displays a doctor's dominance.

However, the values within the pair are not static. For instance, the doctor can become a patient herself and thus lose her dominance in a consultation situation and decision-making. Alternatively, patients are progressively knowledgeable about both medical developments and their legal rights and, for instance, may require a doctor to provide them with a certain treatment.

In my practice analytical deconstruction merges with the associative when the binary pair is approached using the automatic techniques developed by the 1920s Surrealists. These techniques aim to bypass the control of a conscious mind and “pour” the material from unconscious dimensions within. Many Surrealists saw film as best suited for reflecting alternative realities, since it was dream-like and could produce spatial-temporal distortions. Furthermore, Surrealists were strongly engaged with science, especially with psychiatry and psychology, and often borrowed medical concepts in their artistic work (see, e.g., Gamwell, 2002, pp. 243-244). Even though Surrealists did not translate automatic techniques into the camera work, my way of working applies automatic techniques onto the medium of video, approaching a video camera as a tool for “automatic recording.” Compared to film, video has the benefit of being fast in its production and allowing one to work autonomously. Yet, collecting and composing material by automatic techniques does not mean that the outcomes are an unorganized, non-narrative stream of mind. The work with the video material proceeds in phases, in which the initial improvisation is followed by several reflection cycles and re-recordings of the material.

My own body is a fundamental element throughout the work process: besides employing it in artworks as a form of self-representation, it also generates the dynamics in camera movements in my imageries. This is a crucial difference from ethnographic documentaries: I employ different camera angles, as well as a hand-held camera, and thus become a dynamic participant in the situation. Furthermore, I situate myself in the images and, for instance, look and reach directly to the camera and cross the frame of the image in many ways. All these ways remind a spectator of my role as a composer of the images and thus hinder her full immersion into the illusory space. It is considered important here that an audience recognizes the mechanism between the observer and the observed. The shifts between the illusory world the imageries produce and the transparency as a maker of this world aim to activate the spectator to realize the constructed nature of these images.

In the context of my work, a physical equivalence to verbal and visual automatisms is improvisation on set. I utilize both automatic recording and improvisation as tools for creating artistic material. Essential to both these activities is to accept the first thought instead of weighing one idea against another (see Johnstone, 1979, p. 88), and follow it without judgments and thinking of the end product. During automatic recording and improvisation I let the camera run: either by handholding the camera and moving in the space, or by performing in front of the camera. As opposed to executing a planned scene, the improvisation process often resembles problem-finding within a chosen structure (see Sawyer, 2000; also Getzels & Csikszentmihalyi, 1976, who identify problem-finding as an important part of an art-making process). In fact, “problems” fuel my entire art-making process. In order to produce material, I create and tolerate dissonances, for instance, relating to my ambivalent relationship with the research topic and the seeming disconnectedness between the improvised scenes. While the garbled engendering narratives challenge me in decision-making, I am also confronted with the gaps in my moral understanding.

4. Case Study: Two Portrayals of the Doctor-Patient Relationship

I now introduce two video pieces, *Second Opinion* (2008) and *Listening Gaze* (2008), both portraying particular aspects of the doctor-patient relationship (excerpts of the artworks can be viewed online at <http://www.kaisukoski.com/>). In the work process I utilize automatic recording, improvisation as well as deconstruction into binary pairs. The pieces concern a situation in which the actual object of observation, such as a doctor, is absent.

In this process I employ an actual doctor's environment, costumes, and props to situate myself both in the role of a doctor and a patient, and improvise sequences that elaborate on the hierarchical relationship between the two roles. In *Second Opinion* I approach the consultation room as an enacted workspace, an environment in which the roles of the professional and the patient are played out (see Rapport, Doel, & Wainwright, 2008, p. 3). It is thus seen here that doctors becoming doctors is enabled by entering an environment that is prepared to constitute people as doctors (see Hirschauer 1994, p. 343). While I leave the furniture and lighting of the consultation room intact, I employ a manipulated medical instrument, an over-the-table long stethoscope, as means to connect the bodies of the doctor and the patient over a distance. As medical tools have taken an iconic status in medical consultations (Rapport, Doel, & Wainwright, 2008, p. 12), my work addresses the stethoscope as one such iconic tool and mediator between the doctor and the patient. Additionally, the costumes play a crucial role in my improvisations: the doctor's white coat and the patient's underwear have an influence on the body language and choreographies in the consultation room.

While I am exploring the doctor-patient relationship in the absence of an actual doctor and a patient, my own body takes the position as the object of observation. I am playing a role-play, based on the preceding literature survey, interviews, and my personal experiences. The absence of actual bodies is thus replaced by their representations through artistic means. As I perform both roles of the opposition pair myself, the bodies of the characters are identical. This provides an opportunity to focus on choreography, costumes, and props, instead of personal features, as an expression of dominance. Moreover, an abstraction of a given situation, and the absence of text, strengthens this focus as the images are not attached to a personal story.



Figure 1a. Video still from *Second Opinion* (2008) © Kaisu Koski.



Figure 1b. Video still from *Second Opinion* (2008) © Kaisu Koski.



Figure 1c. Video still from *Second Opinion* (2008) © Kaisu Koski.

The two pieces, i.e., *Second Opinion* and *Listening Gaze*, were initiated by interviewing a doctor on her experiences as a patient. In fact, it appeared that doctors might experience the shift into the patient's role even more challenging than other people, since they are knowledgeable about all the things that can be "wrong" and used to being in charge of the consultation situation. Instead of employing the initial interview material directly in the pieces, the experience of shifting from one role to another is translated into a consultation room scenography and performance within. It comprises in one image the short physical distance and the great experiential difference between being a doctor and a patient. The consultation room table, in fact, physically demarcates the border between the two roles and thus creates places with different statuses. As I position myself in this environment, I let the scenography, props, and costumes guide the improvisation. I explore the physical positions in relation to the table, altering the conventional hierarchy and the emotional range both places at the table stimulate. For instance, next to the ordinary two seats on opposite sides of the table, the areas both above and under the table are explored as territories that express a hierarchical status of the given opposition. Furthermore, I stimulate shifts in this dominance relationship in many ways. For instance, the patient holds the stethoscope and listens to the doctor's heart during this consultation (Figure 1a). Moreover, I perform a doctor having an emotional outburst and sinking under the table (Figure 1c) as a response to the patient's collapse (Figure 1b).

Whereas *Second Opinion* is a video piece for a conventional cinematic viewing situation, *Listening Gaze* provides a viewer a physical experience of the doctor-patient binary pair. The installation adapts the theme in an abstraction of a telemedicine application, in which one connects with a doctor or a patient through technology (Figure 2a). Instead of including the actual consultation room environment in the image, the narrow frame reveals only the table and the stethoscope as elements that continue on both sides of the screen. The visitor takes position opposing a medium close-up image of a doctor/patient on a vertical monitor, thus being linked to the character onscreen with a stethoscope (Figure 2b). At the core of the piece are the types of gazes that the onscreen characters project, the hierarchy between the doctor's and the patient's gazes, and the soundscape as a facilitator of this hierarchy. The performance of the characters is inspired by the "scanning" and "pointing" qualities Michel Foucault (2003, p. 121) acknowledges in the "medical gaze": the characters alternate between gazing openly towards the visitor and targeting their glance in one spot only. Even though the doctor and the patient in *Listening Gaze* connect without a dialogue, Foucault (2003, xii) notes the "alliance" between seeing and saying: he describes a clinical experience as a balance between spectacle and speech. In this respect the installation portrays the moment before stating a spectacle; it dwells in the gestureless gaze before the spoken words and intervention.

The medical gaze reaches beyond clinical environments. Sinha (2000, p. 294), in fact, suggests that telemedicine is the ultimate expression of Foucault's medical gaze as it promotes the vision as a primary medium in arriving to diagnosis. *Listening gaze* installation bridges the distance between the doctor and the patient through technology,

but unlike the actual telemedicine applications, it separates them temporally into different ‘time zones’. The onscreen images are recorded beforehand, and the doctor’s performance remains thus the same regardless of the patient’s ‘situation’. Yet, the stethoscope attached to the monitor decreases the distance between these two worlds. It creates a continuum and an illusion of sharing the present moment: through the chord the performer and a spectator share an intimate soundscape of breath and heartbeat. The sound quality and the stethoscope’s pressure in one’s ears add to the fusion of illusory world and the experience of the here-and-now.



Figure 2a. Listening Gaze (2008) © Kaisu Koski. Photo: Martijn de Jong.



Figure 2b. Listening Gaze (2008) © Kaisu Koski. Photo: Martijn de Jong.

5. Reflections

My viewpoint promotes the imaginative quality with which art projects feature the objects of their portrayal. However, as I combine image material from real medical environments with studio-based imageries, I inevitably search for a relationship between ethics and fiction. One could, for instance, argue that medicine cannot truthfully be portrayed through abstract and fictional artistic scenarios. Yet this is not the function of most art projects. It is, in fact, suggested that imaginative exercises of role taking and emphatic enactment, offered by works of fiction can lead to particular knowledge on how to act in order to achieve a morally better outcome (Currie, 1998, pp. 161-162). Furthermore, while adapting methods and concepts from other disciplines, art projects also include capacities in human perception and communication that remain unrecognized in the academic research context. Next to imagination, humor is one of them. Accordingly, my artworks aim to develop a humoristic quality based on awkwardness, for instance, in admitting to

be speechless in the face of a medical dilemma, or executing dry reenactments of medical situations underneath a consultation room table. Due to their imaginative quality art projects thus admittedly create Halls of Mirrors, which represent, deconstruct, and distort medical dilemmas. While distortions can create misconceptions about the “real” world, they also possess the potential to stretch the viewers’ perception and lead to novel insights (Silenzio, Irvine, Sember, & Bregman, 2005, p. 11). Furthermore, regarding cinematic imagination, MacDougall (2006, p. 246) argues that humor can enable one to find an improbable logic in otherwise immeasurable human relationships.

The case study artworks discussed in this article manifest a merge between the artistic and research components: even though the artworks can be, and are, accessed by people without knowledge of the research in health, they could not have been created without the preceding and paralleling research components. I recognize the research as an art generating activity (cf. Tikka, 2008, p. 18, who acknowledges a form of research-based practice in which theoretical understanding inspires practical work). Contrariwise, as in this article, my literal reflections both generate discussion evolving from the artworks and employ them as case studies and illustrations in the texts. The artworks are deriving from research on medical themes, but they subsequently engender the focal points of my scholarly contemplations.

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